Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
COMPREHENSIVE PAIN MANAGEMENT
5734 SPOHN DRIVE
SUITE A
CORPUS CHRISTI, TX 78414

Carrier's Austin Representative Box
15

Respondent Name
Bankers Standard Ins Co.

MFDR Date Received
February 1, 2011

MFDR Tracking Number
M4-11-1865-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 1, 2011: "…Physician saw the patient for an office visit for his compensable injury. Random drug screen tests are necessary to verify the appropriate use of drugs prescribed to claimant for the treatment of the claimant's compensable injury… "

Amount in Dispute: $28.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent was notified of this Medical Fee Dispute on February 17, 2011, but no response was submitted.

Response required by: Bankers Standard Insurance Co.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 14, 2010	Lab	$28.86	$19.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code, §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203(b)(1) sets out medical fee guidelines for professional services
3. 28 TAC §134.203(e) (1) sets out clinical laboratory payment conversion factors.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated August 14, 2010

- 1 The charge for this procedure exceeds the fee schedule
- 2 Procedure code is not valid for this date of service. Resubmit with the correct procedure.

Explanation of Benefits dated December 28, 2010

- 1 The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- 2 Procedure code is not valid for this date of service. Resubmit with the correct procedure.

Issues

1. Were the disputed services submitted with valid procedure codes?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent denied payment as procedure code not valid for the date of service. Review of the submitted medical bill shows the requestor billed G0430QW for the disputed services. 28 Texas Administrative Code §133.203(b)(1) states in pertinent part, "…for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing, correct coding initiatives (CI) edits; modifiers; and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules…" CMS Publication 100-20, Transmittal 653, Change Request 6852, dated March 19 2010, effective April 1, 2010 states, "New test code G0430 was created to limit the billing to one time per procedure and to remove the limitation of the method (chromatographic) when this method is not being used in the performance of the test…When a clinical laboratory that does require a CLIA certificate of waiver performs a qualitative drug screening test for multiple drug classes that does not use chromatographic methods, new test code G0430QW is the appropriate code to bill." Review of CMS CLIA Laboratory Demographic Information Report found on the CMS webpage finds that this requestor has a CLIA certificate of waiver; therefore the billing codes used were in accordance with CMS policy. The division concludes that the requestor billed the services in accordance with 28 TAC §133.203(b)(1) and that the carrier's denial of payment due to an invalid procedure code is not supported.

2. The services in dispute are eligible for payment. 28 TAC §134.203(e) (1) states:

   "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service

   CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2011 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. Review of the documentation finds that the provider sufficiently documented the service in dispute, therefore the total MAR is:

   - G0430 QW 1 Unit = ($15.92 x 1.25%) = $19.90

The total allowable is $19.90, the respondent paid $0.00, an amount of $19.90 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $19.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.